TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Kenneth Arola, D.C.

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-17-2791-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "1st Issue Per Order Pays 500.00
99456 W8 RE RTW Asked and Addressed"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… because Respondent has already remitted complete payment in accordance with the Texas Workers' Compensation Jurisdictional Fee Schedule for the services made subject of this dispute, Respondent asserts that Requestor is not entitled to an additional payment of $150.00."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2016	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work and evaluation of medical care examinations performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is Kenneth Arole, D.C. entitled to additional reimbursement for the disputed service?

Findings

Dr. Arole is seeking an additional reimbursement of $150.00 for a designated doctor examination to determine the ability of the injured employee to return to work performed on December 2, 2016. Per 28 Texas Administrative Code §134.235:

> The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." **In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not** [emphasis added], the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports.

The submitted documentation supports that Dr. Arole performed an examination to determine the ability of the injured employee to return to work. Therefore, the reimbursement for this examination is $500.00. Indemnity Insurance Company of North America reimbursed $350.00 for this examination. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.